

MCCS CLAIM FORM
Administrative Claims for Post Allowance Remedial Payment From
Former Nonappropriated Fund Employees

This claims form is to be completed by claimants who have separated or retired from MCCS. *If you were employed by multiple NAF employers, a separate claim must be filed with each employer. Claims for past employment with a different NAF employer must be filed with that NAF Employer using a claims form for former employees.*

This form should only be used for claims seeking remedial payment of Post Allowance earned between December 1, 2001 and April 24, 2008. If the claim is received by the relevant NAF employer on or before December 1, 2009, then the claim period will extend to December 1, 2001. Claims received after December 1, 2009 will only be considered for a period of time six years back from the date received. Claimants must establish by a preponderance of the evidence that they were eligible for Post Allowance at the time of their employment covered by their claim. For a full explanation of the claims procedures and guidance, go to the following websites: MCCS: <http://www.usmc-mccs.org/>; CPMS: <http://www.cpms.osd.mil/>.

EMPLOYEE NAME _____ SSN _____

MAILING ADDRESS _____

EMAIL ADDRESS _____

FORMER EMPLOYING NAFI _____

DATE OF HIRE _____ DATE OF SEPARATION OR RETIREMENT _____

PERIODS OF EMPLOYMENT FOR WHICH CLAIMING POST ALLOWANCE: _____

LOCATION(S) OF EMPLOYMENT: _____

If you worked for two or more NAF employers during the period of time covered by this claims process, then you must submit separate claims to each NAF employer for the different periods of times that you worked for each NAF employer. Are you, or have you, filed claims for remedial Post Allowance payment with any other NAF employer for a period of time dating back to December 1, 2001? **If Yes, provide the other NAF employer(s), and the dates covered by those other claims:**

During any period of time for which you are claiming Post Allowance eligibility, were you included as a dependent in the calculation of a Post Allowance "with family" rate for your spouse or other sponsor who worked as a civilian for the Federal Government? **No** _____ **Yes** _____ **If yes, provide:**

Dates: _____ Number of dependents claimed by the spouse/sponsor during the relevant time period (including yourself): _____

Spouse/sponsor's rates of pay during relevant time period (attach corroborating SF 50s): .

SUPPORTING DOCUMENTATION: Claimant must obtain the documentation required to establish by a preponderance of the evidence their eligibility for a remedial payment of Post Allowance for the period of time covered by their claim. Employees must be U.S. Citizens and have worked in a Regular full-time NAF position which entitled the employee to Post Allowance during the time period covered by their claim. Part-time, intermittent, and U.S. family member summer/winter hire employees are not eligible. NAF employees in positions in the Flexible employment category are not eligible.

Relevant documents may include:

- A copy of Official Personnel Actions (to include Appointment, Separation, Conversion, Pay Actions and LWOP)
- A copy of Leave and Earnings Statements
- A copy of Official Work Schedules
- A copy of Time and Attendance records
- A copy of W-2s
- In the absence of any of the above, any other relevant document(s) acceptable to the respective NAF employer.

INCLUDE NUMBER OF ELIGIBLE DEPENDENTS DURING PERIOD FOR WHICH CLAIMING POST ALLOWANCE ON PAGE 2 OF THIS FORM.

MCCS CLAIM FORM CONTINUED

DEPENDENT INFORMATION

EMPLOYEE NAME _____ **SSN** _____

NOTE: Eligible dependents for the period for which Post Allowance is claimed do not include:

- A military member who received a military Cost of Living Adjustment (COLA)
- A civilian employee who received a Post Allowance from the Federal Government.
- A dependent who was included as a dependent under a spouse's military COLA or civilian Post Allowance received from the Federal Government.

NAME OF RELATIVE	RELATIONSHIP	DATE OF BIRTH (except spouse)	DATE OF ELIGIBILITY (i.e., Arrival at Post)	DATE OF END OF ELIGIBILITY (i.e., leave Post or no longer dependent)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

ADDITIONAL INFORMATION (AS REQUIRED):

- Marriage License
- Birth Certificates for dependents
- Dependent Identification Card
- Tax Returns

I understand and accept that filing this administrative claim means the following: I have not filed a previous claim for the period of employment described above, nor have I received Post Allowance for that period of employment. I acknowledge that acceptance of remedial payment resulting from a claim filed under these procedures will be a final settlement of all claims against this NAF employer for Post Allowance earned during the period of time covered by this claim, that I may have against the Government arising from non payment of post allowance by this NAF employer.

I certify that to the best of my knowledge and belief, all of the information on and attached to this application is true, correct, complete, and made in good faith. I understand that any knowingly false or fraudulent information on or attached to this application may be punished under any relevant administrative, civil or criminal process.

SIGNATURE OF CLAIMANT _____ DATE SIGNED _____

PRIVACY ACT STATEMENT: Authority for collection of this information is 5 U.S.C. Section 6311 and E.O. 9397. The purpose for which the information will be used is to administer and process your claim for post allowance back pay. The information on this form may be disclosed as generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, as amended. Providing this information is voluntary, however, failure to supply the required documentation may result in the denial of part or all of your claim.

Claims for Post Allowance Payments need to be sent directly to the respective commands. If you were employed between December 1, 2001 and April 24th 2008 in a Regular full time position and you are a U.S. Citizen, you are eligible for Post Allowance payments.

Employed by MCB Butler, Okinawa Japan
Please send Claims to:

MCCS Division
Attn: NAF-HRO Unit 35023
MCB Camp S.D. Butler
FPO AP 96373-5023

Employed by MCAS Iwakuni Japan
Please send Claims to:

MCCS Human Resources Division
PSC 561 BOX 1867
FPO AP 96310-0019

You will be notified upon receipt of this claim. If claim received is not sufficiently substantiated, you will be notified and the notification will include a description of the deficiency, specifying any missing documents required to establish eligibility, and provide a reasonable deadline for receipt of resubmission with additional documentation. The notification will also state that if the additional information is not received by a certain date, the claim will be deemed to have been denied. You will be notified if your claim has been denied.